

# Accreditation to Profitability

**FASA**

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# ASC Experience demonstrates:

- Centers have common Characteristics
- Centers have unique operational aspects
- No two centers are exactly the same

*Essentially all centers strive to be profitable while providing high quality patient care.*

# ASC Management was never easy

- In 2006, we strive to increase 3<sup>rd</sup> Party reimbursement,
- In 1976 we strived to get 3<sup>rd</sup> Parties to recognize the center as a legitimate provider,

Today's ASC administrators face a more complicated management than in the past.

# ASC Management, then & now

Success factors are the same:

- Maximize utilization
- Maximize reimbursement
- Bill and collect effectively
- Contain costs
- Develop an operational process that blends the above while providing high quality care

# Assumptions for today's discussion

- The center is of adequate size
- The floor plan affords some flexibility
- Construction costs were reasonable
- Appropriate equipment purchased at reasonable cost
- Loan terms are reasonable
- Sufficient working capital is available

# Typical Owner Questions

Once accredited, the questions will come:

- Do we still need credit line draw downs?
- Are we past the need for “cash calls”?
- Are all payor contracts negotiated?
- When will we make cash flow break even?
- When will we start making distributions?

# Classic Answers

The answers to these questions rests primarily with how soon can we.....

- Maximize utilization (Doctors bring all their cases)
- Maximize revenue (negotiate all contracts)
- Develop an effective collection program
- Effectively contain costs
- Perfect operating protocol that blends all these factors while delivering high quality care

# And while focusing on these priorities

## Management must successfully:

- Remain compliant with all regulatory standards
- Achieve and improve 3<sup>rd</sup> party reimbursement
- Maintain appropriate staffing and morale
- Maintain medical staff satisfaction
- Remain responsive to the Governing Body
- Continue to provide high quality care
- Have a personal life outside the center

# Short Term vs. Long Term Objectives

Immediately post-accreditation, it is appropriate to focus on short term management objectives.

Short Term = Survive

Long Term = Thrive

# Maximizing Utilization

## (Short Term)

- Typically, all physicians will not immediately shift 100% of their budgeted cases to the center.
- Reasons include:
  - Lack of 3<sup>rd</sup> party coverage
  - Inconvenient / old habits remain
  - Office scheduler “Did not get the memo”
  - Hospital pressure
  - Referring physician pressure
  - Did not have the cases to start with

# Maximizing Utilization

## (Short Term)

### Suggested counter measures:

- 3<sup>rd</sup> Party Coverage: Complete negotiations & inform the surgeons when done,
- Inconvenience: Bring pressure via other doctors,
- Office Scheduler: Visit, educate, tour, buy lunch,
- Hospital Pressure: Determine if real or perceived, deal with on individual basis,

# Maximizing Utilization

## (Short Term)

### Suggested counter measures: (Continued)

- Referring physician pressure: Handle on individual basis, stress economics and patient satisfaction,
- Reporting: Routinely report physician utilization trends to medical staff being careful not to identify specific individuals,
- Visitation: Don't give under utilizers a "Pass". Personally visit them to explore methods to increase their volume.

# Shifting to Long Term Management

After achieving cash flow breakeven, management should transition its focus to the long term.

Failure to do so will result in the center  
*“Losing its compass heading but making great time”*

# Maximizing Utilization

## (Long Term)

Today's market is not conducive to stable utilization without administrative intervention. Reasons include:

- Competing ASCs and hospital programs
- Older staff members nearing retirement
- New procedures performed at other centers

# Maximizing Utilization

## (Long Term)

(Continued)

- Out dated, or wrong, equipment,
- Younger doctors using competing centers,
- Center's financial returns insufficient to motivate additional utilization,

# Counter Measures to Stimulate Utilization

## Competitive Market Elements:

- Analyze market, particularly physician's current interest and needs,
- Study competitor's strengths and weaknesses,
- Develop strategy to counter competitive forces,
- Involve medical staff in the process,
- Be careful, pursue physicians with correct approach and appropriate individual(s),

# Counter Measures to Stimulate Utilization

## Physicians slow down as retirement nears

- Anticipate these situations, (*Don't wait until the retirement party*)
- Consult retiring physician re: replacement physician(s),
- Seek replacement whose volume is on growth curve,
- If possible offer ownership units to entice,
- Assist with banking relationships to facilitate ownership purchase,

# Counter Measures to Stimulate Utilization

New procedures being performed at competing centers:

- Doctors do not identify with stagnant centers,
- Discuss market trends with medical staff and develop strategies for new procedures,
- Duplicate service if it retains or attracts volume,
- Cater to doctors whose specialty could transfer to their own stand alone center (GI).

# Counter Measures to Stimulate Utilization

Out dated, or poorly selected, equipment impediment to volume growth:

*Make certain the physician(s) requesting the new equipment will show up to use it!*

- Assuming you can pay for it, confirm the anticipated revenue increase warrants the expenditure?

# Out dated equipment impediment to volume growth:

- Will additional cases justify new equipment purchase?
- Will performing the new procedure lead to additional procedures?
- Will the additional revenue retire the equipment debt within a reasonable period?

If answers to these questions are favorable, financing becomes the lesser problem as any number of methods are available.

# Younger doctors with growing volume use other centers

It's not coincidence that younger doctors are using competing centers, and not yours.

## **Investigation may reveal:**

- They have invested in the other center,
- Their center offers specific services,
- Their center offers more scheduling flexibility,
- Their center has no one established doctor(s) who dominate a particular specialty,
- The center has been proactive in marketing to younger physicians,

# Younger doctors with growing volume use other centers

Most of the aforementioned situations can be addressed with appropriate counter measures resulting from administration and medical staff collaboration.

# Center's returns insufficient to motivate volume

Additional steps to enhance financial viability are discussed later, but remember...

1. Without sufficient volume, management's actions can do little more than enhance the status quo.
2. Cost containment alone will not drive a center to financial prosperity.

# Reimbursement

## Pricing & Payor Negotiations

- Do not under value your services,
- Charges should exceed cost *(One would hope)*
- Rates are easier to lower than raise,
- Average payor rates do not set your master charge schedule,
- Don't "super size" cash discounts,

# Procedure Revenue and Case Mix

- Some cases will always be more profitable than others,
- Don't "bump" high profit cases to perform low profit cases,
- Cases that cover little more than fixed cost may be okay during off hours,

# Pricing multiple procedures requires caution

- Resist bundling multiple procedures to create a single price,
- Each procedure price should stand on its own from a price / cost ratio.
- Pricing multiple procedures, using center discount policy, is usually better than a bundled fee.

# Payor Contracting

Payor contracting = study & preparation

Understand each payor's:

- a. Market share,
  - b. Market alliances,
  - c. Attitude toward ASCs,
  - d. Contracting approach to ASCs
- Have a strategy before entering negotiations.
  - Concentrate on how the ASC benefits the payor.

# Payor Contracting

## Payors are not the enemy

- Payor rep's expect confrontation,
- Do not open negotiations in an adversarial spirit,
- Payor rep's are usually not the decision makers,
- Work to give Rep's the arguments they need to convince their boss to agree to your terms,

# Payor Contracting

## Your ASC and market precedents

- Your ASC is not obligated by what other ASCs have agreed to accept as payment.
- Research what makes your ASC unique to others,
- Do not immediately accept standard rates,
- Pose differences that warrant higher rates,
- Always be aware of “Silent PPO’s”

# Payor Contracting

## Prepare for renegotiation

- Contracts in years, not “life sentences”
- New centers can only negotiate on projections,
- Counter unfavorable rates with a short contract term,
- Seek agreement to renegotiate on actual performance.
- Determine future terms if performance achieved,

# Payor Contracting

Don't be afraid to walk from the deal

- “Scared money does not win”,
- Don't think “I have to sign”,
- Don't think, “I'll never get decent rates”
- Think “car dealer” & be willing to “walk”,
- Do not sign bad contracts that are not essential,

# Effective Collecting

Without an efficient and effective collection process, much of the effort exerted to achieve the aforementioned objectives will be wasted.

# Effective collections begin with accurate information

Prior to admission, ASC personnel must:

- Verify patient demographic information,
- Verify insurance coverage,
- Define deductible & coinsurance obligation,
- Make payment arrangements with patient at the time of admission,

# Accurate Coding is Essential

- Groupers change routinely, stay current,
- Verify all codes being assigned to the claim,
- Use body of OP report to code, not summary,
- Ensure coder is proficient in using modifiers,
- Do not take the physician's code as "gospel"

# Billing

## Suggested billing policies include

- Claims are filed within 24 hours of surgery,
- A/R days outstanding are less than 45 days,
- Use electronic billing when possible,
- List non-reimbursable codes at bottom of claim,
- Use the EOB for “QI” studies on billing process,

# Collections

- Collect patient balances at admission,
- Set reasonable time frame to clear balances,
- Don't waste staff time working A/R,
- Alert surgeon's office when turning patients to collection,

# Collections *(Continued)*

Turn cases to a “soft approach” / flat fee per case collection service when:

- Second payment promise is broken,
- Phone number changes without new listing,
- There is not patient contact in 60 days,

# Cost Containment

The ASC has two types of operating costs

## Fixed Costs:

- Stay the same irrespective of volume,
- Immune to daily management activity,

## Variable Costs:

- Varies with volume,
- Affected by daily management activity,

# Major Variable Cost Centers

The largest cost centers in an ASC are:

- #1 Salaries and benefits
- #2 Medical Supplies

# Containing Salary Costs

## Budgeting and Scheduling

- Salary schedule is consistent with budget,
- Staffing schedules vary with volume and should be adjusted daily if practical,
  - Target 10 – 11 total man hours per case depending on volume and case mix,

# Containing Salary Costs

## Flex Staffing

- Flex staffing address volume swings,
  - Hire small core of full time staff,
  - Hire larger number of part time and on call staff,
  - Supplement core staff with part time & on call personnel as volume dictates,

# Containing Salary Costs

## Other salary containment considerations

- Cross train to extent possible
  - Pre-op & PACU should be cross trained
  - OR & PACU should be cross trained, to the extent practical
  - Office staff must be cross trained

# Containing Salary Costs

## Other salary containment considerations

- Make certain job assignments match pay grade,
- Use contract services if less expensive than employees,
- Encourage those employees willing to leave early without pay to do so,

# Supply Cost Containment

## Containing Medical Supply Costs involves

- Realistic budgeting
- Prudent shopping and purchasing techniques
- On going physician & staff education
- Efficient utilization techniques
- Monitoring, reporting & adjusting

# Supply Cost Containment

## Budgeting Medical Supplies

- Budgeting & measuring medical supply cost includes:
  - Projected cost per case per specialty,
  - Total medical supply cost per month,
  - Average medical supply cost per patient
  - Medical supply cost as a percentage of revenue,

# Supply Cost Containment

Prudent shopping & purchasing techniques include:

- Joining a group purchasing organization
- Purchasing on consignment
- Maintaining “just in time” inventory
- Sharing large purchases with another ASC
- Returning over stocked items

# Supply Cost Containment

## Physician and Staff Education

- Breaking medical supply related hospital habits requires continuous education.
  - Pursue standardization between procedures / physicians,
  - Review surgical pack make up for added efficiencies & economies,
  - Have low cost supply users teacher others,

# Supply Cost Containment

## Monitoring, Reporting & Adjusting

- The quest to reduce medical supply costs is never ending.
- Imagination & creativity is key to achieving cost reductions,
- Progress has to be monitored, reported, shared & celebrated, then...
- Using lessons learned, strive for continued improvement,

# Key Reporting Tips

A snapshot of center performance can be provided through Critical Management Factors (CMF)

# Critical Management Factors

## Critical Management Factors measure

- Volume
- Revenue
- Salary & Staffing
- Medical Supply Cost
- Accounts Receivable
- Profit

# Critical Management Factors

## Volume

- **By Month:** Can be deceptive as working days can vary three days month to month,
- **By Day:** Average number of cases per day provides a better trend indicator.
- **Avg. cases / day / month:** The best method of detecting actual monthly volume trends,

# Critical Management Factors

## Revenue

- **Gross Revenue:** A meaningless number but for calculating contractual allowance,
- **Contractual Allowance:** Interesting but not functional, *(An effective depressant)*
- **Net Revenue:** Meaningful number against which other ratios are based,
- **Avg. Revenue / Case:** A meaningful number, that reflects dollar impact of case mix trends,

# Critical Management Factors

## Salaries & Staffing <sup>(1)</sup>

- **Salaries as % of Net Revenue:** Range between 23%-26% is good,
- **Total manhours / case:** 10 – 11 manhours per case is good,
- **FTE's:** Interesting but not as precise as manhour measurement,

(1) Assumes multi-specialty with volume in 250-300/mo. range

# Critical Management Factors

## Medical Supplies

- **Supply Cost / Mo:** Gross measure, interesting for reporting, less helpful with management,
- **Supply Cost / Case:** More precise measure and useful as tool,
- **Cost as % of Net Revenue:** Should range 1%+/- of 18% of net revenue.

# Critical Management Factors

## Accounts Receivable

- Electronic billing uses to extent possible,
- Claims are filed within 24 hours of surgery,
- A/R days outstanding 45 days or less,
- Patient balances cleared within 60 of insurance payment

# Critical Management Factors

## Profit

- Calculated on accrual basis,
- Reflected as whole number,
- Reflected as a percentage,
- On annual basis, reflected as ROI

Thank You